



Communicable Disease Branch Coronavirus Disease (COVID-19) Bi-Weekly Key Points

September 14, 2021

The North Carolina Division of Public Health (NC DPH) Communicable Disease Branch will be releasing COVID-19 weekly key points that includes information discussed on the weekly Tuesday Local Health Department call. Recordings of the call will not be made available; please use the information below as a summary of the topics presented on the call. As guidance changes, please use the most recent information provided. For questions, contact the NC DPH Communicable Disease Branch 24/7 Epidemiologist on Call at **919-733-3419**.

Important Updates

- **New:** NCDHHS LHD Bi-Weekly Webinar 9 14 2021.pdf (file attached)
- **New:** CDC EpiX Vigilance for Measles and Polio.pdf (file attached)
- **Updated:** Find My Testing Place Web Upload SeptemberWk2.xlsx (file attached)

Helpdesk and Data Cleanup *Anita Valiani*

- Review and submit all cases prior to May 2021 for auto-report to take place.
- If you have a person duplicate please email/call helpdesk, don't just assign it to the state in the investigation trail. We have a small team cleaning up the person deduplications constantly so we can try to help resolve it.
- If you have event deduplications please try to complete them to the best of your abilities, if they are in your county and negative events please keep separate; if they are positive (open) events you should keep the earliest event for the person. If you cannot see the other events on the person please contact helpdesk, and we understand there may be a lot of combinations of closed/open events, and we plan to share guidance about how to clean soon.
- Please be patient with us as we are training at full capacity with current staffing on our side. We are working to help staff up the CCNC staff and LHD staff at the same time. If you are assigned a class time, please attend so the seats don't go to waste.
- Email helpdesk if you have any questions ncedsshelphelpdesk@dhhs.nc.gov

Infection Prevention in Healthcare and in Long-term Care *Amy K. Braden*

On Friday September 10th, the CDC updated its recommendations on Infection Prevention for Healthcare Personnel, including Healthcare Personnel with SARS-CoV-2 infection or exposure, and the Infection Prevention in Nursing Homes and Long-Term Care Facilities.

Level of Community Transmission

Recommendations based upon community transmission levels have previously utilized the county percent positivity rate provided by CMS but now the CDC is defining community transmission levels from their [COVID-19 Data Tracker](#), using additional infection prevention and control measures for the determination.



The Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

Source Control

- CDC continues to recommend source control for everyone in a healthcare setting, aligning with community guidance. Updated the allowance for fully vaccinated individuals (who are not symptomatic or have had close contact or high-risk exposure to someone with SARS-CoV-2 infection for 14 days) in healthcare facilities located **in counties with low to moderate community transmission** may be allowed to choose to not wear source control or physically distance when they are in well-defined areas that are restricted from patient access (staff meeting rooms, break rooms)
 - They should continue to wear source control in areas where they could encounter patients, unvaccinated HCP, HCP of unknown vaccination status and in communities of substantial to high transmission of COVID-19
 - Note that no counties in NC are in the low or moderate community transmission categories at this point.

Testing

- Updated the testing guidance for asymptomatic HCP with a higher-risk exposure, regardless of vaccination status, and patients with close contact to have a series of two viral tests for SARS-CoV-2 infection
 - The first test should be performed immediately (but not earlier than 2 days after exposure) and if negative, again 5-7 days after the exposure

Quarantine

- In general, quarantine is no longer recommended for fully vaccinated patients with exposure to SARS-CoV-2 or those patients who have had SARS-CoV-2 infection in the prior 90 days

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

- Symptomatic HCP: should be excluded from work and prioritized for testing. Negative results from at least one FDA Emergency Use Authorized COVID-19 viral test indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 may be performed at the discretion of the evaluating clinician when determining return to work criteria
- Asymptomatic HCPs who were exposed should be tested using a series of two viral tests. Testing is recommended immediately (but not earlier than 2 days after the exposure) and if negative, again 5-7 days after the exposure
 - Vaccinated HCPs should utilize universal source control while in the healthcare facility for 14 days following their exposure
- Circumstances when work restrictions might be recommended:
 - Asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days who are [moderately to severely immunocompromised](#) and might be at increased risk for reinfection
 - Unvaccinated asymptomatic HCP for whom there is concern their initial diagnosis of SARS-CoV-2 might have been a false positive (asymptomatic individual with positive antigen test that did not have a confirmatory NAAT performed)
 - Fully vaccinated HCP who are [moderately to severely immunocompromised](#)
 - When directed by public health authorities



- Unvaccinated HCP with higher-risk exposures

Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes

Outbreak Response to a newly identified infection in any HCP or nursing home-onset infection in a resident. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based testing.

1) Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-CoV-2 infection

- All HCP with higher-risk exposure and residents with close contacts, regardless of vaccination status, should be tested immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later.
 - **Unvaccinated and partially vaccinated residents** who had close contact should be placed in quarantine for 14 days with the exception for a resident that has tested positive within the prior 90 days
 - **Fully vaccinated residents** who had close contact should wear source control for 14 days following exposure
- If testing of close contact reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individuals
 - A facility-wide or group-level (e.g., unit, floor) approach should be considered if all potential contacts cannot be identified or managed with contact tracing

2) Broad-based approach may be utilized if a facility does not have the expertise, resources or ability to identify all close contacts and should investigate the outbreak at the facility-level or group-level

- Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later.
 - **Unvaccinated and partially vaccinated residents** should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.
 - If known, close contacts should be managed as such, and may require quarantine
 - **Fully vaccinated residents** do not need to be restricted to their rooms or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority
- If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days and no further testing is indicated.
- If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days.



Routine Screening Testing for HCP

Facilities are now to use the [CDC COVID Data Tracker](#) for reports on the level of community transmission. [CMS QSO-20-38-NH](#) has updated Table 2 to reflect the terminology of the COVID Data Tracker. Intervals of routine testing are only applicable to unvaccinated or partially vaccinated staff.

- Low (Blue) – not recommended
- Moderate (Yellow) – Once a week
- Substantial (Orange) – Twice a week
- High (Red) – Twice a week

Visitation

CDC recommends following CMS guidance for visitation criteria. We anticipate updated guidance to be forthcoming and will update when we have further information.

Contact Tracing in Schools *Erika Samoff*

- In attached slides are instructions for how to use CCTO to track contacts in schools and how school nurses can be onboarded into CCTO.
- Here is the link to the Contact Tracing in Schools survey; please provide your feedback here:
https://docs.google.com/forms/d/e/1FAIpQLScGiVW5aWSnlyCQTqCp7CQIRyV_RMxpgFAKV7Pj2BcT2QbokQ/viewform

Find My Testing Place

Please review the updated 'Find My Testing Place LHD' Excel file weekly to ensure information is up to date and accurate. Please send the updated files or any related questions to testfinder@castlighthalth.com

Question & Answer

Q: Union County School Board voted to do away with contact tracing and quarantine for those not testing positive. Can they do this? what is the recourse?

A: I hope Betsey's overview helped. Confirming that we'll be getting a letter out broadly to clarify the responsibility and authority of the LHD and also the state law that requires schools to cooperate with LHD communicable disease investigations.

Q: Dr. Moore, can you speak to what you are seeing with influenza?

A: We are seeing very little influenza activity right now, though we are seeing increased positive tests in our sentinel surveillance system for other respiratory viruses (RSV and rhinovirus). Currently surveillance data for influenza and other respiratory viruses is on pages 17 and 18 of the weekly respiratory report here: <https://covid19.ncdhhs.gov/media/380/open> We will add additional influenza data starting MMWR week 40, which is the beginning of October.

Q: Can you send Zack's slide deck following this presentation?

A: Yes, the slides will accompany the weekly key points.

Q: Given the number of cases in schools are we looking at any changes to isolation and quarantine strategy in the future?



A: Yes - alternative quarantine options are being evaluated, but no changes planned at present. We are not considering any changes to isolation guidance.

Q: Does anyone know if schools have opted to close for 2 weeks in an attempt to clear a cluster? Specifically, public schools.

A: We are aware of some schools and school systems that have dismissed students in response to clusters or high case numbers. We don't generally recommend closure/dismissal as a control measure - encourage maximizing all other layered prevention strategies and closing only if necessary due to too many staff or student absences.

Q: Any news about variant Mu?

A: Mu is now included in our weekly reports - page 11 at <https://covid19.ncdhhs.gov/media/380/open> Small numbers of Mu identified going back to May, but no indication that it's taking off in NC or nationally at this point.

Q: Does vaccination status matter for monoclonal antibody administration? Is it mainly meant for those who have not completed their series or those who are unvaccinated?

A: mAbs should be considered separate from vaccination. Individuals who are vaccinated can be eligible for mAbs if they meet criteria. Persons who get mAbs should wait 90 days to be eligible for vaccination against COVID-19.

Q: Speaking of flu vaccines, is there any way we can distribute some flu vaccines in the hub and spoke model along with the three COVID vaccines? This would allow our partners, particularly state vaccine vendors, to co-administer flu with COVID-19, increasing our vaccination rate for the flu.

A: Flu vaccine distribution is different than COVID-19 vaccines. The eligibility for those programs is different and make it difficult to merge the two completely.

Q: How many mL is 50 micrograms?

A: In the current presentation, a Moderna 50 microgram dose would be 0.25mL. Things can change and we are waiting for CDC guidance for what the future may look like.

Q: We have had a question about the CDC revoking the use of PCR tests in July and they are supposed to be discontinued 12/31/2021. What does this mean for PCR testing?

A: RT-PCR-based tests are one type of laboratory-based nucleic acid amplification test (NAAT), which continue to be described by both CDC and FDA as the "gold standard" of diagnostic testing for COVID-19. RT-PCR tests have been reliably used to successfully detect SARS-CoV-2, the virus that causes COVID-19, since February 2020. Many SARS-CoV-2 diagnostic tests that have received emergency use authorization (EUA) from FDA use RT-PCR.

As described on CDC's website, the discontinuation of the CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel, only applies to that specific test. It does not affect any other SARS-CoV-2 test that has received EUA from FDA. There are no performance concerns with this test or any other RT-PCR test.



Instead, CDC is recommending that laboratories routinely conduct influenza testing in addition to COVID-19 testing, and CDC is encouraging laboratories to adopt tests like the CDC Influenza SARS-CoV-2 (Flu SC2) Multiplex Assay that look for both viruses.

Q: Any idea if/when CVMS will allow scheduling of the booster? will this go live when the authority is given to proceed?

A: This will likely go live when authorization and clarity is given to who is eligible.

Q: Will the waiver to temporary reinstate retired or inactive RNs or LPNs that currently expires December 31st, be extended to assist with boosters and continued 1st & 2nd dose vaccinations?

A: Please send this question to susan.little@dhhs.nc.gov and to beth.lovette@dhhs.nc.gov and they will provide the answers.

Q: Any guidance on mandatory COVID-19 vaccines for LHD?

A: There is no guidance currently. The White House announcement may have implications, but it is unknown at this time. Rulemaking process needs to move forward from the White House executive order signed last week.

Q: Is state going to help LHDs (through covid vaccine vendors) to provide flu shots in covid vaccine events?

A: No plans are being made at this time with state support.

Q: We can co-administer vaccines but if not given at same time do we need to wait in-between?

A: No need to wait between.

Q: How will the equity in the rollout of booster doses be ensured?

A: NC DHHS will continue to monitor the data and work with local stakeholders to ensure market gaps are addressed.

Q: Can you explain the 6/8-month windows being April 20th (6 month) and Feb 20th (8 month) vs March 20th and Jan 20th? Isn't it based on 6/8 months from last dose or am I not understanding the timeline? Thank you!

A: In an 8-month scenario any person who completed a primary series (1st and 2nd dose for mRNA vaccines) would be eligible for a vaccine on 9/20. The numbers are to indicate who is immediately eligible for a booster dose once authorized. Again, we do not know the specifics of eligibility and have provided information merely for planning purposes.

Q: We have had reports where people are going to vendors for vaccines that give gift card incentives and have been heard saying they have received (5 or more) multiple vaccines to obtain multiple gift cards. Any suggestions on how to prevent this since we do not ask for ID?

A: We have also heard those rumors. In at least one case, the vaccinator did request an ID, since the vaccinator recalled vaccinating the individual with the first dose. Unfortunately, with large volume settings remembering an individual is just not possible. We've shared these concerns with our incentives team to consider ways that we could address if the incentive program is extended.

Q: Given that these vaccines may not provide protection within nasopharynx to prevent endemic cold-like symptoms but rather prevent systemic, moderate to severe COVID, hospitalizations, and deaths - do we think



that booster doses will help with vaccinated breakthrough infections or the current cold-like s/s we are seeing among vaccinated? What should our messaging be about the boosters? Is it to prevent breakthroughs or waning of vaccine? The public seems to be confused about breakthrough infections.

A: Primary intent would be to prevent severe illness and death, as with the primary series, but will likely have an impact on overall infections also as with primary series.

Q: CMHRP and CMARC programs. Last year, they put that on hold but with the delta surge we haven't had any direction.

A: With Medicaid managed care live as of July 1, we do not anticipate that the Prepaid Health Plans will modify expectations of the CMHRP and CMARC programs.

Q: What listserv were the emails sent to for booster dose planning?

A: Those went to local health directors from the "vaccineinfo" email address. If you are a health director and did not receive it, please email Beth Lovette at beth.lovette@dhhs.nc.gov

Q: Have you all cross-matched NC COVID and CVMS and analyzed re: breakthrough cases lately, and what are you finding?

A: Yes, we match NC COVID and CVMS cases weekly. Data is reported weekly in the respiratory report here: <https://covid19.ncdhhs.gov/media/380/open>

Q: Can you please help us interpret PCR positive with antigen negative lab results in both a symptomatic and asymptomatic patients with no history of past infection? How do we treat these?

A: In general, a patient that has a PCR positive following an antigen negative would be considered positive and isolated. The antigen testing flowchart can be referenced on CDC's antigen guidance page: <https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html#using-antigen-tests-congregate-living-settings>

Q: Do you anticipate a difference in the data when PCR tests are no longer used?

A: There will not be a time when PCR tests are no longer used.

Q: How does this new Infection in NH and LTC compare to CMS guidance?

A: The CDC guidance and CMS guidance are aligned. The CMS testing guidance has been updated to reflect the CDC updates: <https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf> The CMS visitation guidance update is expected soon.

Q: Does the new guidance for not quarantining/testing LTC residents also apply to other congregate settings such as detention centers or homeless shelters?

A: This guidance is for healthcare settings and long-term care facilities.

CDC corrections guidance can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html>

CDC Guidance for homeless shelters can be found here:

<https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>

Q: Has this testing changed for CMS guidance as well?



A: Yes, the changes in testing are mirrored in both the CDC and CMS guidance. CMS updated their document on Friday Sept 10th as well.

Q: We get a lot of questions regarding tracking of the occurrences of reinfections in those who were previously infected vs breakthrough infections with vaccine? Is NC tracking reinfections in NC COVID and where may we find this information?

A: We are working on reinfection data collection and will be sharing information with you all soon.

Q: Is the Panther COVID-19 TMA lab test equivalent to a PCR? We are seeing providers use a myriad of tests for kids, and it is getting more and more difficult for the LHD and school nurses to interpret them.

A: Yes. TMA is a type of NAAT and similar to PCR. <https://www.cdc.gov/coronavirus/2019-ncov/lab/naats.html>

Q: For fully vaccinated Health care providers who work in LTC setting who are living with a positive case at home unable to isolate (children), what are the recommended testing intervals since exposure is ongoing.

A: It would be recommended to repeat those testing intervals (2 days after initial exposure and then repeat at routine intervals of 5 days if negative) until the positive case has completed their isolation period, as the close of that period would be the end of their exposure. The HCP should monitor themselves for symptoms and use source control. Additionally, consideration could be given to work restrictions. This guidance can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html> If further clarification is needed, please email us at nc.covid.ip@dhhs.nc.gov

Q: A quick follow-up question because I don't think I was clear...re: the eligibility timelines that have been shared...

A: There is no official eligibility criteria booster doses. This is yet to be determined by the FDA/ACIP/CDC. For the purpose of using the planning tools. If a person completed a primary series for an mRNA vaccine prior to February 20th, 2020 would be instantly eligible for a booster does if eligible if considered under the 8-month scenario.

Q: Curious why April 20th is only 5 months from September 20th but being used for the 6-month window? Same for February 20th/8-month window...just a bit confused by these dates! Thanks!

A: We are sorry for the confusion. Please refer to the emails sent out to the LHD directors on 9/3, 9/10 and 9/13 for more clarity.

Q: With new LTC guidance is it still a 28-day interval between last positive case and end of outbreak?

A: This is the technical definition of the end of an outbreak, so facilities will remain on our table until 28 days has passed. However, testing only needs to occur for 14 days, and visitation may also occur per published CDC/CMS guidelines.

Q: The two-step testing is that just for HCP or everyone that is a contact?

A: The two-step testing is recommended for people who are not fully vaccinated. HCP (regardless of vaccination status) who have a higher-risk exposure should be tested with the two-step method. This guidance can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

**Division of Public Health
Communicable Disease Branch**

Q: I need to update the backup vaccine coordinator in our provider enrollment portal. I can't get it to change. How can I do that?

A: The COVID-19 Vaccine Provider Help Desk is available for providers and organizations to call and receive live support for COVID-19 vaccine and CVMS questions, issues, or requests:
Call (877) 873-6247 and select option 1 for COVID-19 questions.